# MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

| REPORT TITLE | McAfee Army Health Clinic – Occupational History / Social History / Family History | OTSG APPROVED *(Date)* *(YYYYMMDD)* |
|---|---|---|

Date of exam: ___/___/____ Interviewer:_____

Type of exam: ☐ Pre-placement ☐ Change of Position ☐ Annual

1. Name: _____
2. Date of Birth: _____
3. Home Address: _____

_____

4. Telephone number (work/home):_____
5. Marital status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
6. Race/Ethnic group: ☐Asian ☐Black ☐White ☐Hispanic ☐American Indian ☐Other _____
7. Do you have any current medical problems? ☐ Yes ☐ No
8. List significant medical conditions or illnesses. Please list diagnoses, when first identified, whether it was work-related, and if it has resulted in current problems.

| When Diagnosed (Year) | Diagnosis | Work - Related (yes/no) | Current problem (yes/no) | Any Associated Current Problems? |
|---|---|---|---|---|
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9. Have you ever been hospitalized, when, for what condition, and are there any current problems associated?

| Year | Hospital Diagnosis | Associated Current problems |
|---|---|---|
| | | |
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*(Continue on reverse)*

| PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | *DATE (YYYYMMDD)* |
|---|---|---|
| | | |

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

10. Do you have any current work restrictions (i.e., within the past month)?

| Restriction type (e.g.: lifting, driving) | Specific Work Restriction | Duration | Start Date |
|---|---|---|---|
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11. List all current medications (prescribed and those not requiring a prescription):

| Medication | Medical condition | Type of condition (e.g., cardiovascular. For nurse use only!) |
|---|---|---|
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12. List of medications, chemicals, or other things you are allergic to:

| Allergic to | Reaction | Severity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

13. Health Habits

Smoking:

- ☐ Nonsmoker
- ☐ Past Smoker: ____ packs per day for ____ years
- ☐ Smoker: ____ packs per day for ____ years

Chewing tobacco:

- ☐ Nonuser
- ☐ User: ____ cans/packets per week for ____ years

(Continue on reverse)

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Alcohol intake:

- ☐ Never drinks
- ☐ Drinks: _____ drinks per week _____ drinks per occasion

Exercises: ____ minutes _____ times per week (workouts or sport events).

Number of **clinic or physician visits** over the past 1 year _____

Number of **work related injuries or illnesses** over the past 1 year _____

Number of **worker's compensation claims** over the past 1 year_____

14. WORK HISTORY (questions a – g are for annual exams; question h is for preplacements)

a. Current job title: _____

b. Number of years in **current** position? _____

c. Bldg #/or name:_____

d. Supervisor/phone #:_____

e. Is job description current? (review SF 78)_____

f. List any **new** work-related exposure hazards since last year:_____

_____

g. List all types of personal protective equipment **currently** work:_____

_____

(Continue on reverse)

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|---|---|

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h. Please list all jobs you have had including short-term, part-time, full-time, and military experience. If you can recall, also please note the possible chemicals, dusts, fibers, fumes, radiation, biologic agents (viruses, molds, bacteria), and physical agents (heat, cold, vibration, noise) that you were exposed to on the job.

| Dates From | Dates To | Name of Company | Job Title | List All chemical or physical exposures | Illness or Injury? List Diagnoses | List Protective Equipment Used |
|---|---|---|---|---|---|---|
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*(Continue on reverse)*

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- ☐ HISTORY/PHYSICAL
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15. SPECIFIC WORKPLACE POTENTIAL EXPOSURES OVER THE LAST YEAR:

| Hazard | Yes | Route* | Comments |
|---|---|---|---|
| Asbestos | ☐ | | |
| Cadmium | ☐ | | |
| Chlorine | ☐ | | |
| Heat | ☐ | | |
| Ionizing Radiation | ☐ | | |
| Laser/Microwave | ☐ | | |
| Lead | ☐ | | |
| Solvents | ☐ | | |
| Welding fumes | ☐ | | |
| Other | ☐ | | |

* Route of exposure: enter skin, lungs, eyes, ingestion, or other.
Comments: duration, frequency, estimated intensity of exposure, & whether PPE was being used at the time of potential/actual exposure.

16. FAMILY HISTORY

Since the last surveillance exam, have any relatives developed the following conditions?

| YES | NO | | FAMILY MEMBER/COMMENTS |
|---|---|---|---|
| ☐ | ☐ | Allergies | |
| ☐ | ☐ | Eczema | |
| ☐ | ☐ | Cancer | |
| ☐ | ☐ | Eye diseases | |
| ☐ | ☐ | Heart diseases | |
| ☐ | ☐ | High blood pressure | |
| ☐ | ☐ | High blood lipids | |
| ☐ | ☐ | Diabetes | |
| ☐ | ☐ | Asthma | |
| ☐ | ☐ | Lung diseases | |
| ☐ | ☐ | Liver diseases | |
| ☐ | ☐ | Kidney disorders | |
| ☐ | ☐ | Blood disorders | |

*(Continue on reverse)*

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| | | | |
|---|---|---|---|
| ☐ | ☐ | Joint diseases | |
| ☐ | ☐ | Neurological diseases | |
| ☐ | ☐ | Other | |

17. NONOCCUPATIONAL ACTIVITIES/HOBBIES

| YES | NO | | DESCRIBE POTENTIAL EXPOSURE HAZARDS |
|---|---|---|---|
| ☐ | ☐ | Building models | |
| ☐ | ☐ | Carpentry | |
| ☐ | ☐ | Car/boat repair/restoration | |
| ☐ | ☐ | Ceramics/pottery | |
| ☐ | ☐ | Farming | |
| ☐ | ☐ | Gardening | |
| ☐ | ☐ | Guns/hunting | |
| ☐ | ☐ | Home repair/construction | |
| ☐ | ☐ | Power tools/generators | |
| ☐ | ☐ | Refinishing | |
| ☐ | ☐ | Welding | |
| ☐ | ☐ | Other (specify) | |

18. FEMALE/MALE REPRODUCTIVE HISTORY

FEMALE: Have you ever been pregnant? ☐ Yes ☐ No

MALE: Do you have children? ☐ Yes ☐ No

BOTH: Please enter the following information about your history.

| Date | Live Birth | Stillborn | Miscarriage | Abortion | Birth defect? | Type of birth defect. |
|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |

(Continue on reverse)

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| | | | | | | |
|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |
| | ☐ | ☐ | ☐ | ☐ | ☐ Yes ☐ No | |

Other reproductive system problems:

- _____

Additional Comments:

*(Continue on reverse)*

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